Society Proceedings

AMERICAN NEUROLOGICAL ASSOCIATION.

Held in Washington, May 7, 8 and 9, 1907.

The president DR. HUGH T. PATRICK, in the Chair.

(Continued from p. 117.)

Loss of Comprehension of Proper Names. By Dr. Frank R. Fry. (See this JOURNAL, 1907, p. 617.)

Dr. M. Allen Starr said this was a very interesting case. It is unfortunate that in the study of aphasia too little attention is paid by students to building up speech in the infant's mind. Now those of us who have watched the development of vocabulary in infancy will recollect that the first words spoken are nouns. A child at the age of two does not put together two or three words. He names individuals and single objects, and his whole vocabulary is these nouns. It is not until a child is two and a half to three years old that the connective parts of speech, as "mama is sick" will come out. Dr. Starr said it seemed to him therefore that in the study of aphasia we must regard the manner of the building up of our processes of language, and it would look as if this defect in the use of nouns was a defect in the most fundamental of the processes of language. Now we have the converse in other cases. Dr. Starr said he had had a patient who was educated or grew up on the borders of France and Germany, in Alsace, and as a little boy he spoke French. As he got to be a little older, eight or ten, a result of the German war was a change in his language and he had to learn German. Then he came to this country and finally learned English. He had a gradually advancing aphasia in which he lost his English. Then for a time Dr. Starr had to talk German or French to him. After that he lost German, and Dr. Starr had to talk French to him entirely. Dr. Starr said he watched the case for three years and observed progressive loss of speech until just before death the man was completely aphasic. The last acquisition of language was blotted out first. The fundamental seemed to be lost to a certain extent, but the later acquisition was lost first.

Dr. B. Onuf said he had been much interested in listening to Dr. Fry's paper, and he would try to classify the case from the observations which Dr. Fry had reported. It seemed to Dr. Onuf that one ought to think chiefly of two possibilities; one, that this was a case of optic aphasia as Freund has described it, and the second possibility that there was a small circumscribed lesion of the third frontal convolution. In the case of optic aphasia we are likely to find in addition to the aphasic disturbance also visual disturbances, such as hemianopsia, or soul-blindness, more or less pronounced. Also there is very likely to be in many forms some word-deafness. In cases of "frontal aphasia," as we might say, if the lesion is small, there may be at first complete aphasia, and then very quickly a return of the vocabulary takes place, and the functional loss may then manifest itself almost in the manner that Dr. Fry had described; that is, the words that are acquired with most difficulty are those that will be lost chiefly and perhaps solely. In distinguishing the two forms it is very essential to make a careful study of accompanying symptoms. One is more likely in frontal aphasia to have symptoms on the part of the centres situated in the lower part of the central convolutions; that is, on the part of the facial, on the part of the tongue, and on the part of the pharynx; while in the forms of optic aphasia we are more likely to have hemianopsia, hemianesthesia and word-deafness. In a frontal aphasia there is also agraphia. From Dr. Fry's description it would seem that there were no visual disturbances, no soul-blindness, no word-deafness; and that would make it more probable that the lesion was situated anteriorly; *i. e.,* in the third frontal convolution.

Dr. G. M. Hammond said the case reminded him of one that he reported of a driver who was struck on the side of the head in the temporal region by another man who had a loaded whip-handle in his hand. The man did not become unconscious for some twelve hours. He then had a convulsion and became unconscious, but regained consciousness very quickly. He was taken into the hospital. He was somewhat stupid, and could not say any proper names. He could say all other words except proper names. In describing how he was hurt he said, "a (indicating a man), hit me on the (pointing to his head) with a (imitating as near as he could the whip-handle)." He was operated upon, and a fracture of the temporal bone and a sub-dural clot covering the superior temporal convolution were found. The latter was removed, and in the posterior third of the superior temporal there was a hole in the brain which extended inward about an inch, and was about as big around as a lead pencil. This man was under observation for about two years and a half, and he slowly regained power of saying proper names. At no time was there any loss of the idea of things. He would take up a cup and saucer and use it; he could not say cup and saucer to save his life. At the end of a year's time he could say these words, but it was still impossible for him to use words of three syllables. At the present time he has regained his entire power of speech. Whether the word center for proper names is exactly in the area involved in this case or not it is difficult to say. The probability is that it is not always in the same place in all individuals. As Dr. Starr has just said, the fundamental speech of a child is the learning of proper names, and probably the memorization of these names occurs in the cells of the superior temporal, which are in the highest state of development at that time. Now this may not always be exactly in the same place in the temporal lobe. The cells in the temporal lobe may be more developed in one child than in another, and hence may not always have the same topographical locality in all individuals, but it would seem in this case, and others, that the proper name center is in the superior temporal convolution.

Dr. H. H. Hoppe said that in connection with this subject, and especially in connection with what Dr. Hammond had just said, he (Dr. Hoppe) would like to briefly mention a case which was under his observation for a good many years. The man was injured by having a brick fall on his head, and it produced a compressed fracture of the temporal bone over the temporo-sphenoidal lobe. The interesting feature in this case was that the fundamental language in this man was German, and his acquired language, which was very imperfectly spoken, was English, and he lost his naming sense in the German and not in English. For instance, if shown an object, in a very broken way he would give the English name for it, but had lost the German name. This might indicate that there is probably a separate area for naming in the different languages. He spoke rather glibly in broken sentences, and for two or three years, as long as Dr. Hoppe knew him, he never regained the power to speak nouns in German.

Dr. B. Onuf said that Dr. Hoppe's observation may find some psychological explanation; that is, uneducated people in learning a foreign language are very likely to unlearn their own; in fact they come to the point where they cannot speak any language.

Dr. Fry said that he had carefully examined his patient, and there were no visual defects that he could discover. He was disposed to accept Dr. Onuf's idea that this must have been a lesion in the anterior lobe; *i. e.*, if there were any process which might be called a single lesion; at any rate he could not conceive of the process as being other than psychic in a sense, or involving primarily the region of control or formation of language.

The Classification of Psycho-Neurotics, and the Obsessional Element in Their Symptoms. By Dr. G. L. Walton. (See this JOURNAL, 1907, p. 489.)

The Use of Social Intercourse as a Therapeutic Agent in the Psychoneuroses. A Contribution to the Art of Psychotherapy. By Dr. Sidney I. Schwab. (See this JOURNAL, 1907, p. 497.)

Dr. A. R. Allen said he did not know to what extent this manner of treatment is common or uncommon among neurologists here in America, but seven years' association with Dr. S. Weir Mitchell in his office has shown him many such cases; in fact, he could say that it is the usual modus operandi of treatment of these cases coming to the office. As to the question of a year and a half or two years or three years under observation, he said that whereas the case may stay in the town and be a regular office patient for three or four or five months, it is a frequent practice to send that case out into the world, making the patient feel that the office is a harbor in case of rough weather ahead, and this relationship lasts for two or three years, and in almost every case with the greatest benefit. It is very interesting to see these points put down upon paper, because it is too little done, and one reason we as neurologists do not keep these cases is because men do not realize the importance of this therapeutic treatment. After all, we get very many more cases of neurasthenia and hysteria or neurasthenia combined with hysteria than we do of cortical lesions.

Dr. S. E. Jelliffe said it seemed to him that Dr. Schwab had emphasized, as he so frequently has at previous meetings, the desirability of a little more definiteness in therapeutic work in general. It is well known that the methods as outlined are widely employed, but are employed by many in a haphazard manner. These patients are told to go to the theatre or to read books, without telling them what to see or what to read; to go about and see their friends, without ourselves having investigated the friends. The ideas that Dr. Schwab has formulated and put in such definite, tangible form are ideas that all can apply with more definiteness than has been done. Each and every man knows that in his own city there are different conditions; at the same time with all the disadvantages if we will take the trouble to make it a systematic method it can be done with more consecutive purpose than as a rule we do employ.

A Case of Matricide and Attempted Suicide, with Brief Psychologic Analysis. By Dr. W. K. Walker. (See this JOURNAL, p. 144.)

Have the Forms of General Paresis Altered? By L. Pierce Clark and C. E. Atwood. (See this JOURNAL, 1907, p. 553.)

Dr. Diefendorf said he believed that the difference in the percentage depends in part upon the basis of distinction or the standards used by the different men. The fact that the speakers had not entered more fully into the description of the various types led Dr. Diefendorf to believe that this is true. In his own experience he believed that the expansive type should be confined to those cases where the symptoms of megalomania are continuously present for many months, together with a certain degree of psychomotor excitation and the emotional state of euphoria. On the other hand, the demented types he believed should be confined to those cases where deterioration predominates. In the demented cases there are undoubtedly short periods of megalomania, but they are insignificant compared with the progressive and rapid dementia which predominates in the picture. These cases seen for the first time and only during such periods would unqustionably be called cases of megalomania. The depressive type should be confined to those cases where the depressive symptoms predominate through many months. Judged by this standard he found in a series of his own cases, numbering 272, that the expansive cases represent 50 per cent., that the demented cases represent 40 per cent., and the depressive only 7½ per cent. He failed to find any true agitated cases except as they represent the terminal periods of the demented type, or short episodes in the expansive type. He did find, however, that there is a considerable group of cases that might be called manic-depressive type, because of the transitions from the megalomanic to the depressive stage and vice versa. One may question the desirability of grouping cases of dementia paralytica at all. The only advantage seems to rest in the fact that we get a clearer insight into the course of the disease; for instance, the megalomanic type in his cases averaged seven months longer duration. Again in the matter of the paralytic attacks he found that the expansive cases present far more paralytic attacks, and furthermore, also in reference to the remissions, he found that remissions are far more prevalent in the expansive type than in either of the other types. Dr. Diefendorf said that he himself did not believe that in recent years there had been such a marked alteration in the type of dementia paralytica. The apparent change is rather the result of observations by different men who have employed different standards of comparison.

Dr. P. C. Knapp said he thought Dr. Diefendorf had pointed out one possible explanation of the idea that the type of general paralysis has changed of late years. Of course our methods of diagnosis have improved and we recognize to-day many cases as being paretic which were not so recognized thirty or forty years ago, but at the same time it is distinctly rare, in Dr. Knapp's experience very rare, to encounter the typical case of general paralysis with the extreme delusions of grandeur, such as was described by Falret and Calmeil in the original accounts of general paralysis, and which was regarded as the classical picture. Of course there can be no distinct line drawn between the different classes. There are a good many cases probably which Drs. Clark and Atwood included in their expansive type, who show after all comparatively little in the way of expansion. It is more a dementia with a mild euphoria and an easy-going way of looking at things, but without any of the real expansive conditions such as were formerly described, and that would explain the difference between such figures as they present and the opinion which Mendel has maintained, that there was a distinct increase of the simple dementing type in comparison with former years.

Dr. C. K. Mills remarked that personal experience must be looked at askance, even if it has extended over many years. His own experience has extended over thirty years, and from the first years of the period until to-day he has seen very many cases of general paresis in public and private practice. The general impression from that experience is that we have less cases exhibiting the grandiose delusions in their most typical form.

Dr. G. M. Hammond said he must agree with Dr. Mills. In his experience in the last twenty years or more the picture of paresis has certainly changed. Where the expansive delusions and grandiose ideas were plentiful years ago, now in private practice they are not so. He said he would not say that a majority of cases have not some degree of expansiveness, but they do not present it to the same extent, not nearly to the same extent that they did in former years. In many cases we see we cannot find any trace of grandiose ideas at all. In regard to the causation, Dr. Hammond believes there is only one cause and that is syphilis; that alcohol, excessive venery, debauchery of all kinds, are simply contributory causes, and there must be the syphilitic basis, whether we have found it or not, in order for these contributory causes to develop the disease.

An Experimental Study in the Etiology of Epilepsy.—By Dr. Smith Ely Jelliffe. (To be published in this JOURNAL.)

Dr. L. P. Clark said he had but one point of regret that Dr. Jelliffe should have carried out his experiments on rabbits. They are the most epileptogenous of all animals. If he had done his experiments on dogs or apes it would have been different. As far as the changes in the cortex are concerned it would seem to Dr. Clark as though there has been a distinct trend of late years in showing that these gliosis changes are entirely secondary to the cellular changes. It seems perfectly natural and rational, and it has been shown more or less conclusively and definitely by a host of workers that the primary changes take place in the parenchymatous elements and the secondary change was, in greater part at least, due to glial replacement.

Dr. Jelliffe said that if Dr. Clark would subsidize him he should be only too glad to carry on the experiments on the animals suggested. Apes, as is well known, cost four and five hundred dollars apiece.

So far as the remarks regarding secondary changes are concerned, it seems to Dr. Jelliffe that it is absolutely true that the glial changes are secondary to the destruction of the nerve cells, but the method by which the secondary process takes place is the point which Dr. Jelliffe tried to make in this preliminary contribution.

Multiple Neuritis, Accompanied by Degenerations in the Cord. Exhibition of Microscopical Specimens.—By Dr. Graeme M. Hammond.

A New Diagnostic Sign in Recurrent Laryngeal Paralysis. By Dr. Alfred Reginald Allen. (See this JOURNAL, p. 141.)

Hysteria in Children. By Dr. John Jenks Thomas. (To be published in this JOURNAL.)

Dr. Mills asked what age had been fixed by Dr. Thomas as the limit in considering hysteria in children? The etiology of hysteria in children is to be sought for in two things—a neuropathic heredity and an intense neuropathic environment. These cases in children usually occur in families in which at least one of the parents is a hysteric or a neuropathic, not infrequently one of them or some other near relative having had mental or hysterical manifestations. One of the most interesting cases he ever saw was a child ten years old, the daughter of a woman whom he had treated some years before for hystero-epilepsy of the most typical form. He was called to see a case of supposed meningitis with convulsions, and found the patient was the child of the woman he had formerly treated, and that the case was one of hystero-epilepsy. Dr. Thomas replied that the age of limitation he selected was fifteen years.

Dr. P. C. Knapp said that his experience in the hysteria of childhood is much more limited than Dr. Thomas's has been, but he wished to introduce one point which Dr. Thomas raised; namely, in regard to the care in diagnosis, to be sure that we are not dealing with organic disease. It is so constant an experience to be called to a case and informed that it is a case of hysteria, and to find on examination that it is undoubtedly one of organic disease, that Dr. Knapp thinks that point cannot be emphasized too strongly. Only the other day he was asked to see a case of alleged hysteria in an adult, presenting the Brown-Séquard complex with a Babinski reflex and various other symptoms of organic disease.

Dr. S. E. Jelliffe said that Dr. Knapp's remarks tempted him to express some experience he had had in traumatic hysteria in children. There the problem of diagnosis becomes often more acute, especially in litigation cases, and he recalled two instances only last year coming under his observation, of traumatic paraplegia in children of eleven and twelve years, following a trolley car accident, in which the diagnosis was of extreme interest. From his point of view they were both hysterical cases, although in the contest in court an attempt was made to show the organic nature of the paraplegia, but subsequent investigation (calling on these children and finding they had both gone off to a party) confirmed the diagnosis of hysterical paraplegia. Hysterical paraplegia in children of this age, it seems to Dr. Jelliffe, is of extreme interest, and Dr. Thomas's suggestion that he had found paraplegias more common among children than other forms of the graver hysterical accidents is suggestive.

Dr. Morton Prince said that his experience, so far as this class of cases with which Dr. Thomas deals is concerned, would coincide with Dr. Thomas's. Of course his experience with children has been smaller. There is one point which Dr. Prince would like to make, and that is regarding the classification of hysteria. The answer to this question of the frequency of hysteria depends very largely upon what syndrome we include in hysteria. There is a very marked tendency in the profession to limit hysteria in the adult to those cases which contain the classical stigmata of analgesia, anesthesia, paralysis, and physical stigmata of that kind. He thinks we are getting away from this notion and that, on the contrary, those cases represent a very small proportion of the hysteria in adults.

Unquestionably a very large number of cases occur without any of these stigmata, and express themselves in what used to be called neurasthenia. Neurasthenia as observed in a very large number of cases is hysteria. He does not say that all neurasthenia is hysteria, but that the symptom-complex of much hysteria is neurasthenia. Some people prefer the term psycho-neurosis, but we are dealing with patients who are essentially of the same class as those other cases of hysteria, which exhibit the stigmata of anesthesia, etc. Now in children we do see the neurasthenic type, though not so commonly as in adult life. This should not be overlooked. But as Dr. Prince understands it, that is not the type to which Dr. Thomas has referred here. He limits himself to hysteria with physical stigmata, but if the neurasthenic type is included it must increase somewhat the frequency of hysteria in childhood.

Dr. M. Allen Starr said that hysteria in children is a very rare condition in his hospital and private experience. He said he could recall a number of cases in which the so-called hysterical syndrome had been present for some little time in cases that have subsequently proved to be brain tumors, so that he is always on his guard when the family physician says there are hysterical symptoms in a child under fourteen years of age, and he (Dr. Starr) always wants an ophthalmoscopic examination.

Dr. J. J. Thomas said he would agree with most of the statements which had been made in the discussion of this paper. He thought that the statistics which he has of the cases in the Children's Hospital show that hysteria is a rare condition in children, and he should say it was much rarer here than in Germany. The tendency to call a thing hysteria where the symptoms do not form any snydrome of symptoms is a dangerous one, and he emphasized, of course, in his paper that one should always be on his guard against a mistake in diagnosis. The history of the cases where the child is supposed to have meningitis which disappears quickly, is not enough to warrant us in calling these cases hysteria. Dr. Thomas said he should be much more likely to class them among the serous meningitis cases. Moebius makes the statement that only symptoms which can be imitated are hysterical. Dr. Thomas thinks that is certainly going too far, when we consider the hysterical convulsion. The same thing is true of other symptoms. Then one should remember (a thing which he has brought out in the paper more fully than in the verbal abstract) that after organic disease one sometimes finds one little characteristic which may be defined as a hysterical remain. There again, as in adults, one cannot always make a positive diagnosis between an organic disease and a functional one, the hysterical condition, except perhaps by watching the case. That is true of many of these hysterical cases in children, where we have to deal with only one or two symptoms, and it is only by the sudden appearance and disappearance of these symptoms, their acting in a way we know an organic disease could not act, that we can call the cases hysterical.